Medicare Learning Network
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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which creates a 3% add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through December 31, 2016. Similar to temporary rural add-on provisions in the past, claims that report a rural state code (code beginning with 999) as the Core Based Statistical Area (CBSA) code for the beneficiary's residence will receive the additional 3% payment. The CBSA code is reported associated with value code 61 on home health claims. The Centers for Medicare & Medicaid Services is working to expeditiously implement the home health rural add-on provision, Section 3131(c), of the PPACA. Be on the alert for more information about this provision and its impact on past and future claims.

MLN Matters® Number: MM6873

Related Change Request (CR) #: 6873

Related CR Release Date: April 2, 2010

Effective Date: Cost reporting periods starting on or after July 1, 2010, through June 30, 2011

Related CR Transmittal #: R1940CP

Implementation Date: July 6, 2010

Extension of Reasonable Cost Payment for Clinical Lab Tests Furnished by Hospitals with Fewer Than 50 Beds in Qualified Rural Areas

Provider Types Affected

Hospitals with fewer than 50 beds in qualified rural areas who submit claims to Medicare fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for providing clinical laboratory tests to Medicare beneficiaries are affected.

What You Need to Know

CR 6873, from which this article is taken, announces that Section 3122 of the Patient Protection and Affordable Care Act re-institutes reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals this could affect services performed as late as June 30, 2012. You should make sure that your billing staffs are aware of this payment extension.

Background

1. On February 13, 2004, in response to Section 416 of the Medicare Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 3130 to implement procedures to provide reasonable cost payment for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods during the 2-year period beginning on July 1, 2004.
2. On February 2, 2007, in response to Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, CMS issued CR 5493 to extend the 2-year provision outlined within CR 3130 for an additional cost-reporting year. Because CR 5493 was implemented beyond the original sun-setting date outlined in CR 3130, FIs and A/B MACs were instructed to adjust any claims for laboratory services that should have received reasonable cost payment under TRHCA, Section 105.
3. Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 extended these payments to include cost reporting periods beginning on or after July 1, 2004 through June 30, 2008. For some hospitals, this affected services performed as late as June 30, 2009.
4. Now in CR 6873, from which this article is taken, CMS announces that Section 3122 of the Patient Protection and Affordable Care Act re-institutes these payments for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011. For some hospitals, this could affect services performed as late as June 30, 2012.

Please be aware that your FI or A/B MAC:

- Will use the Medicare Zip Code File to identify qualified rural areas that, in the context of CR 6873, are those with population densities in the lowest quartile of all rural county populations; and
- Effective for the entire cost reporting period beginning on or after July 1, 2010 through June 30, 2011 will calculate payment on a reasonable cost basis for outpatient clinical laboratory services from qualified hospitals on a Revenue Code 030X line submitted on either a 12X or 13X Type of Bill (TOB).

Finally you should remember that your FI or A/B MAC will not hold beneficiaries liable for any deductible, coinsurance, or any other cost-sharing amount.

Additional Information

You can find the official instruction, CR 6873, issued to your FI or A/B MAC by visiting *http://www.cms.gov/Transmittals/downloads/R1940CP.pdf* on the CMS website. You will find the updated *Medicare Claims Processing Manual,*

Chapter 16 (Laboratory Services), Section 30.3 (Method of Payment for Clinical Laboratory Tests - Place of Service Variation) as an attachment to that CR.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.